

# 1 050 W 05646 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film 242 5-15-59 ams

5671

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>				c. LENGTH OF STAY IN 1b <b>3 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US ARMY HOSPITAL ABERDEEN PROVING GROUND, MD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROGER</b> Middle <b>ALLEN</b> Last <b>ANDERSON</b>				4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 4, 1936</b>	
9. AGE (In years last birthday) <b>22</b> yrs.		IF UNDER 1 YEAR Months <b>22</b> Days <b>22</b> Hours <b>22</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier - 2d Lt</b>		11. BIRTHPLACE (State or foreign country) <b>South Dakota</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Harvey Willard Anderson</b>			
14. MOTHER'S MAIDEN NAME <b>Unknown</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>1959</b>			
16. SOCIAL SECURITY NO. <b>504-34-6206</b>				17. INFORMANT <b>Official Army Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of brain</b> DUE TO <b>Gunshot wound</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Skull fracture</b> DUE TO <b>same as a above</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>17 to 19 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Suicide</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Gunshot wound of the head</b>			
20c. TIME OF INJURY Month, Day, Year <b>1030 a. m. May 4 19 59</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Aberdeen</b>				20g. (County) <b>Harford</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>1225 May 4, 1959</b> , to <b>5:30 May 5, 1959</b> , that I last saw the deceased alive on <b>3:30 May 5, 19 59</b> , and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Lawrence R Ward</i>				ADDRESS (Street, city or town, state) <b>US Army Hospital A berdeen Proving Gd Md</b>			
DATE SIGNED <b>5 May 59</b>				PHYSICIAN'S NAME (Type) <b>LAWRENCE R WARD, CAPT</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>5-7-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>YANKTON</b>		22d. LOCATION (City, town, or county) (State) <b>YANKTON, SOUTH DAKOTA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Blight, Inc</i>				ADDRESS <b>6009 Harford Road</b>		24a. REC'D BY REGISTRAR <b>MAY 12 '59</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kimes</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

H5310

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BARNHURST, 18

## CERTIFICATE OF DEATH

Date of Death

Name of Deceased

Sex

Age at Death

Cause of Death

Place of Death

Date of Burial

Place of Burial

Name of Burial

Sex

Age at Death

Cause of Death

Place of Death

Date of Burial

Place of Burial

Name of Burial

Sex

Date of Burial

Place of Burial

Cause of Death

Place of Death

Date of Burial

Cause of Death

Sex

Age at Death

Cause of Death

Place of Death

Date of Burial

Place of Burial

Cause of Death

Place of Death

Date of Burial

Place of Burial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 652 CERTIFICATE OF DEATH

05647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>	
c. LENGTH OF STAY IN 1b <b>15 Yrs.</b>		d. STREET ADDRESS <b>Dallam Place</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Dallam Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ayres</b> Last <b>Ayres</b>		4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 6, 1876</b>
9. AGE (In years last birthday) yrs. <b>82</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	
11. BIRTHPLACE (State or foreign country) <b>Harford Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Mc Kee</b>		14. MOTHER'S MAIDEN NAME <b>--- Wann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mary c. Ayres</b>		Address <b>Dallam Place, Bel Air, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chr. Cardio-Vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>24 Hrs.</b> <b>10 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <b>19</b> p. m. Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 2, 1953</b> , to <b>May 30, 1959</b> , that I last saw the deceased alive on <b>May 30, 1959</b> , and that death occurred at <b>6:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Forest Hill, Md.</b> DATE SIGNED <b>May 30, 1959</b>			
ACTUAL SIGNATURE <b>Willard P. Hudson</b> M.D.		DATE SIGNED <b>May 30, 1959</b>	
PHYSICIAN'S NAME (Type) <b>Willard P. Hudson M.D.</b>		ADDRESS (Street, city or town, state) <b>Forest Hill, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>June 3, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Ignatius</b>	22d. LOCATION (City, town, or county) (State) <b>Hickory, Harford Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Inter</b> ADDRESS <b>W. Broadway + Williams St. Bel Air, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			



## 5672 CERTIFICATE OF DEATH

Reg. Dist. No.

05648

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norrisville</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nicholas</b> Middle <b>N.</b> Last <b>Ayres</b>		4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 24, 1876</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Shawsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Ayres</b>		14. MOTHER'S MAIDEN NAME <b>Alice Ann Norris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>205-22-3834A</b>	
17. INFORMANT <b>Arnold Ayres</b>		Address <b>Fawn Grove, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis, ch. protatis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>due to infirmities of old age.</b> (c) <b>generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr. 19, 1959</b> , to <b>May 9, 1959</b> , that I last saw the deceased alive on <b>May 7, 1959</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Stewartstown, Pa.</b> DATE SIGNED <b>May 9, 1959.</b> ACTUAL SIGNATURE <b>Norman H. Gemmill</b> M.D. <b>Stewartstown, Pa.</b> PHYSICIAN'S NAME (Type) <b>Norman H. Gemmill</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/11/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ayres Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>White Hall, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hurt</b>		24a. REC'D BY REGISTRAR <b>MAY 12 '59</b>	
ADDRESS <b>Stewartstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1932

15586

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1880</u></p>		<p>4. Age: <u>52</u> years</p>	
<p>5. Place of birth: <u>North Wales, Pa.</u></p>		<p>6. Usual residence: <u>123 Main St., Baltimore, Md.</u></p>	
<p>7. Date of death: <u>Dec 15, 1932</u></p>		<p>8. Time of death: <u>10:30 AM</u></p>	
<p>9. Cause of death: <u>Myocardial infarction</u></p>		<p>10. Place of death: <u>Home</u></p>	
<p>11. Signature of attending physician: <u>[Signature]</u></p>		<p>12. Signature of registrar: <u>[Signature]</u></p>	
<p>13. Date of registration: <u>Dec 16, 1932</u></p>		<p>14. Office of registration: <u>Baltimore, Md.</u></p>	

RECEIVED  
BALTIMORE, MD.  
DEC 16 1932  
DEPARTMENT OF HEALTH

## 3653. CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>5 mos.,</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>L.</u> Last <u>Bowers</u>			4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13, 1916</u>		9. AGE (In years last birthday) <u>42</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>			13. FATHER'S NAME <u>Guy M. Taylor</u>		
14. MOTHER'S MAIDEN NAME <u>Gertrude S. Brown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>?</u>			17. INFORMANT <u>Ruth P. Taylor, Bel Air, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESP. FAILURE</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTATIC CARCINOMA.</u> DUE TO (c) <u>CARCINOMA OF BREAST</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>4 hrs.</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>23 MARCH</u> , 19 <u>59</u> , to <u>9 MAY</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5 MAY</u> , 19 <u>59</u> , and that death occurred at <u>3:40 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H.P. Sidwell</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>401 Franklin St., Bel Air, Md.</u> <u>11 May 59</u>			
PHYSICIAN'S NAME (Type) <u>H.P. Sidwell</u>		401 Franklin St., Bel Air, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 12, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	
22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford, Md.,</u>		24a. REC'D BY REGISTRAR <u>May 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard L. Thomas Jr.</u>		ADDRESS <u>Abingdon, Maryland.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
JAMES M. BROWN		Male		35	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
April 15, 1954		Baltimore, Md.		Heart Disease	
TIME OF DEATH		MANNER OF DEATH		OCCUPATION	
10:30 AM		Natural		Teacher	
RESIDENCE		HUSBAND		WIFE	
1234 Elm St., Baltimore, Md.		Mary E. Brown		John A. Brown	
DATE OF BIRTH		PLACE OF BIRTH		FATHER	
April 15, 1919		Baltimore, Md.		James M. Brown	
MOTHER		SISTER		BROTHER	
Mary E. Brown		John A. Brown		James M. Brown	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
April 15, 1954		Baltimore, Md.		Heart Disease	
TIME OF DEATH		MANNER OF DEATH		OCCUPATION	
10:30 AM		Natural		Teacher	
RESIDENCE		HUSBAND		WIFE	
1234 Elm St., Baltimore, Md.		Mary E. Brown		John A. Brown	
DATE OF BIRTH		PLACE OF BIRTH		FATHER	
April 15, 1919		Baltimore, Md.		James M. Brown	
MOTHER		SISTER		BROTHER	
Mary E. Brown		John A. Brown		James M. Brown	



## 3654 CERTIFICATE OF DEATH

05650

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>				c. LENGTH OF STAY IN 1b <b>21 HRS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp.</b>				e. STREET ADDRESS <b>616 LEWIS</b>			
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>BOY</b> Last <b>BRENDLE</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>7</b> Year <b>19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 6, 19 59</b>	
9. AGE (In years, lost birthday) yrs. <b>20</b>		IF UNDER 1 YEAR Months <b>54</b>		IF UNDER 24 HRS. Hours <b>20</b> Min. <b>54</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Wm K. Brendle</b>				14. MOTHER'S MAIDEN NAME <b>Evelyn Jane Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>				16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Dr. Wm K. Brendle</b> Address <b>HAVRE DE GRACE MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE DUE TO PULMONARY</b> <b>773.5</b> DUE TO <b>HYALINE MEMBRANE DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PREMATURITY (WEIGHT 5# 5 1/2 oz)</b> (c) <b>—</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>6 May</b> , 19 <b>59</b> , to <b>7 May</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7 May</b> , 19 <b>59</b> , and that death occurred at <b>2:35</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert Norman MD</b>				DATE SIGNED <b>6 May 1959</b>			
PHYSICIAN'S NAME (Type) <b>Robert Norman MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-8-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ANGEL HILL Cem</b>		22d. LOCATION (City, town, or county) (State) <b>HAVRE DE GRACE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Madison Mitchell</b> ADDRESS <b>Havre de Grace Md.</b>				24a. REC'D BY REGISTRAR <b>—</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

2071353XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the Health Department. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

Item 18, Film 245 5/27/59 cap

5673

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 245 5/27/59 cap

05651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air, Md.</b> c. LENGTH OF STAY IN 1b <b>2</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>—</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air, Md.</b> d. STREET ADDRESS <b>Alliance</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FATE</b> First Middle Last <b>BROWN</b> 4. DATE OF DEATH Month Day Year <b>5 9 1959</b>		5. SEX <b>M</b> 6. COLOR OR RACE <b>C</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>4/10/1920</b> 9. AGE (In years last birthday) <b>38 39</b> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labour</b> 11. BIRTHPLACE (State or foreign country) <b>Hartsville Ga.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Brown</b> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>W.W. 2</b> 16. SOCIAL SECURITY NO. <b>Unknown</b> 17. INFORMANT <b>James Hill Savannah Ga.</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Hill</b> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>491X</b> (c), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Paul F. Guerin</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) <b>PAUL F. GUERIN</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>5-10-59</b> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>5/17/59</b> 22b. DATE THEREOF <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Sylvester</b> 22d. LOCATION (City, town, or county) (State) <b>Sylvester Ga.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Kraus</b> 24a. REC'D BY REGISTRAR DATE <b>MAY 18 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

5674

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 1 FilmG243 5/27/59 cap

05652

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>				STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>rural Bel Air</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>rural Jarrettsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Private Home Graftons Road, Churchville</u>				STREET ADDRESS <u>Rocks, RD</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Maudie Elizabeth Brown</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 16, 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 22, 1890</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Renick, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harvey Brown</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Boggs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>233-34- 5252</u>		17. INFORMANT & ADDRESS <u>Isaac M. Brown Rocks, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
1443X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						24 days	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive C-V-D</u>						20 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/28/50</u> , 19....., to <u>5/16/59</u> , 19....., that I last saw the deceased alive on <u>5/16/59</u> , 19....., and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert B. Smith</u>				DATE SIGNED <u>5/16/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>5/21/1959</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	
24. REC'D BY REGISTRAR <u>DATE MAY 19 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kutz</u>			
				ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u>			
				LOCATION (City, town, or county) (State) <u>Bel Air, Maryland</u>			



105528

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased person, full name as given at birth

John William Smith  
Age 45 years  
Sex Male  
Race White  
Married

2. Date of death  
12 days

3. Place of death  
Home

4. Cause of death  
Heart failure  
Due to  
Hypertension

5. Duration of illness  
10 days

6. Name of attending physician  
Dr. J. H. Jones

7. Name of medical examiner  
Dr. A. B. Brown

8. Name of coroner  
Mr. C. D. Green

9. Name of funeral home  
Mr. E. F. White

10. Name of cemetery  
U. S. F.

11. Name of burial place  
Home

12. Name of town  
Baltimore

13. Name of county  
Baltimore

14. Name of state  
Maryland

15. Name of district  
Baltimore

16. Name of registrar  
John W. Smith

17. Name of registrar  
John W. Smith

18. Name of registrar  
John W. Smith

19. Name of registrar  
John W. Smith

20. Name of registrar  
John W. Smith

21. Name of registrar  
John W. Smith

22. Name of registrar  
John W. Smith

23. Name of registrar  
John W. Smith

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John W. Smith

25. Name of registrar  
John W. Smith

26. Name of registrar  
John W. Smith

27. Name of registrar  
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30. Name of registrar  
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31. Name of registrar  
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John W. Smith

35. Name of registrar  
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36. Name of registrar  
John W. Smith

37. Name of registrar  
John W. Smith

38. Name of registrar  
John W. Smith

39. Name of registrar  
John W. Smith

1. Name of deceased person, full name as given at birth  
2. Date of death  
3. Place of death  
4. Cause of death  
5. Duration of illness  
6. Name of attending physician  
7. Name of medical examiner  
8. Name of coroner  
9. Name of funeral home  
10. Name of cemetery  
11. Name of burial place  
12. Name of town  
13. Name of county  
14. Name of state  
15. Name of district  
16. Name of registrar  
17. Name of registrar  
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37. Name of registrar  
38. Name of registrar  
39. Name of registrar  
40. Name of registrar

5675

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05653

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>US Route 70 40</u>		d. STREET ADDRESS <u>Custer St.</u>	
3. NAME OF DECEASED (Type or print) <u>Judy G. Burgess</u> First Middle Last		4. DATE OF DEATH <u>May 30 1959</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 10, 1938</u>
9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk-Steno.,</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>	
11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William R. Burgess</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Lynch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>007-38-6702</u>	
17. INFORMANT <u>William R. Burgess,</u>		Address <u>Sanford, Maine.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident* - car with tractor-trailer</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. <u>5-30 19 59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Route 70</u>	20f. (City or town) (County) (State) <u>Jaffa Harford MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		5-30-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June, 3, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Fairfax, Virginia.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McCombs Jr</u>		ADDRESS <u>Abingdon, Maryland.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Sanford, Maine

5655 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Convalescent Home</u>				e. STREET ADDRESS <u>Wheel Rd., Rt. # 2, Bel Air, Md.</u>			
3. NAME OF DECEASED (Type or print) First <u>Ennice</u> Middle <u>Cheek</u> Last <u>Cheek</u>				4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1873</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Ashley Cheek</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
14. MOTHER'S MAIDEN NAME <u>Ada Johnson</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. Cecil Cheek, Wheel Rd., Rt. # 1, Bel Air, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia, terminating</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) <u>Chronic hypertensive cardio-vascular disease</u> <u>15 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>June</u> , 1939, to <u>May 25</u> , 1959, that I last saw the deceased alive on <u>May 25</u> , 1959, and that death occurred at <u>10:35AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u>				DATE SIGNED <u>May 25, 1959</u>			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 27, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt., Carmel</u>		22d. LOCATION (City, town, or county) (State) <u>Emmorton, Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. McCowan Jr.</u> ADDRESS <u>Abingdon, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18

1885

DATE OF DEATH

MASSACHUSETTS

DEPARTMENT OF HEALTH

STATE OF MASSACHUSETTS

DEPARTMENT OF HEALTH

STATE OF MASSACHUSETTS

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DEPARTMENT OF HEALTH

STATE OF MASSACHUSETTS

October 1885

Virginia

none

A. J. Johnson

Amory Creek

none

to

to the town of Amory Creek

Amory Creek, Virginia

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Amory Creek, Virginia



**1**  
FOR STATE  
HEALTH DEPT.

5656

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05655

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BEL AIR</b>	c. LENGTH OF STAY IN 1b <b>2 YRS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>32 BEL AIR</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>12 LANGFORD PLACE</b>		d. STREET ADDRESS <b>1 12 LANGFORD PLACE</b>	
3. NAME OF DECEASED (Type or print) <b>THEODORE EUGENE CORNELL</b>		4. DATE OF DEATH <b>MAY 16 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 12, 1907</b>
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NAT. GAS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GAS LINES</b>	11. BIRTHPLACE (State or foreign country) <b>WEST VA.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>LAFAYETTE CORNELL</b>	
14. MOTHER'S MAIDEN NAME <b>NANCY PETHTEL</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>233-16-5072</b>		17. INFORMANT <b>MRS ORA CORNELL</b> Address <b>12 LANGFORD, BEL AIR</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 ACUTE CORONARY THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>15 MIN</b> DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Philip W. Heuman</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>PHILIP W. HEUMAN</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>MAY 19, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Willow Island</b>		22d. LOCATION (City, town, or county) (State) <b>Harvey W. Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph J. Foster</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 19 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05058

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5058

OR STATE  
HEALTH

*[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various administrative notations.]*



*[Vertical text along the right edge of the page, likely a filing or processing stamp.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be completed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film 6257, 2-29-60

## 5657 CERTIFICATE OF DEATH

05656

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>		c. LENGTH OF STAY IN 1b <b>7 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Almshouse- Harford County</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>24 Havre de Grace</b>	
3. NAME OF DECEASED First <b>Margaret</b> Middle <b>Elizabeth</b> Last <b>LEE</b> <b>Curry</b>		4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 20, 1871</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>John Wright</b>		14. MOTHER'S MAIDEN NAME <b>Martha Crew</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>SAMUEL G. CURRY</b>		Address <b>HAVRE DE GRACE, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chr. Cardiovascular Disease</b> DUE TO (c) <b>?</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 1952</b> , 19____, to <b>May 1959</b> , 19____, that I last saw the deceased alive on <b>May 29, 1959</b> , 19____, and that death occurred at <b>2 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Forest Hill, Md.</b> DATE SIGNED <b>5/30/59</b>			
ACTUAL SIGNATURE <b>Willard P. Hudson</b> M.D.		PHYSICIAN'S NAME (Type) <b>Willard P. Hudson M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6-1-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROCKY HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HARFORD MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Madison Mitchell</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 3 '59</b>	
ADDRESS <b>Havre de Grace, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

## 02551

## 5658 CERTIFICATE OF DEATH

05657

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Havford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Havford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hawn Ridge Rd</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Eller</u> First <u>M</u> Middle <u>Eduards</u> Last		4. DATE OF DEATH <u>May</u> Month <u>22</u> Day <u>1959</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 21, 1871</u> yrs. <u>88</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Havford Co. Md U.S.A.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James H. Bowman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Sheridan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>no</u> (If yes, give date of service)		16. SOCIAL SECURITY NO. <u>212-14-1496B</u>	
17. INFORMANT <u>M. Edwards</u> Address <u>Hawn Ridge Rd</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2</u> days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>May 4, 1959</u> to <u>May 22, 1959</u> that I last saw the deceased alive on <u>May 22, 1959</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.	
22. ACTUAL SIGNATURE <u>F.P. Snodgrass</u> M.D.		22b. ADDRESS (Street, city or town, state) <u>Burlington Md</u> DATE SIGNED <u>5/23/59</u>	
22c. PHYSICIAN'S NAME (Type) <u>F.P. Snodgrass</u>		22d. LOCATION (City, town, or county) (State) <u>Havford Cr, Md</u>	
22e. DATE THEREOF <u>May 25, 1959</u>		22f. NAME OF CEMETERY OR CREMATORY <u>Rock Run</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Bailey</u> ADDRESS <u>Burlington Md</u>		24. REC'D BY REGISTRAR <u>May 28 '59</u> 24b. REGISTRAR'S SIGNATURE <u>C. L. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
CERTIFICATE OF DEATH

00000

Name of Deceased <i>John H. [illegible]</i>		Age <i>81</i>	
Sex <i>Male</i>		Race <i>White</i>	
Date of Birth <i>Nov 22, 1872</i>		Date of Death <i>Nov 22, 1952</i>	
Place of Birth <i>St. Louis, Mo.</i>		Place of Death <i>Baltimore, Md.</i>	
Cause of Death <i>Heart Disease</i>		Immediate Cause <i>Myocardial Infarction</i>	
Disease or Injury <i>Coronary Artery Disease</i>		Duration of Illness <i>24</i>	
Occupation <i>None</i>		Signature of Physician <i>[Signature]</i>	
Signature of Registrar <i>[Signature]</i>		Date of Registration <i>Nov 22, 1952</i>	

5659

## CERTIFICATE OF DEATH

Reg. Dist. No.

05658

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>1 Hr. 55 min.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				24			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hosp</u>				d. STREET ADDRESS <u>952 CHESAPEAKE DR.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>GRILLE</u> Last <u>GRILLE</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/14/1914</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FEDERAL EMPLOYEE</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>GEORGE BAEKEY</u>				14. MOTHER'S MAIDEN NAME <u>NELLIE BOYD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Hande Shae Md.</u>				Address <u>Hande Shae Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>YEARS</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>4/29</u> , 19 <u>59</u> , to <u>5/2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/2</u> , 19 <u>59</u> , and that death occurred at <u>10:53</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Irwin Randall Ross</u> M.D. <u>200 N. Union Ave</u>							
PHYSICIAN'S NAME (Type) <u>IRWIN RANDALL ROSS</u> <u>Haure de Grace, Md.</u>							
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Buried</u>				22b. DATE THEREOF <u>5/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>	
22d. LOCATION (City, town, or county) <u>Hande Shae Md</u>				(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hande Shae Md</u>				ADDRESS _____		24a. REC'D BY REGISTRAR <u>DATE MAY 7 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00558

Reg. Dist. 10

## CERTIFICATE OF DEATH

5650

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 10

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 10-15-1900		5. PLACE OF BIRTH BOSTON, MASS.	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. RACE White		9. RELIGION Roman Catholic		10. EDUCATION High School	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. PLACE OF DEATH Home		14. TIME OF DEATH 10:30 AM		15. SIGNATURE OF DECEASED James J. Jones	
16. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		17. SIGNATURE OF CLERGYPERSON Rev. J. H. Smith		18. SIGNATURE OF WITNESSES John Doe, Jane Doe		19. SIGNATURE OF REGISTRAR John Doe		20. SIGNATURE OF DECEASED James J. Jones	
21. PLACE OF INTERMENT St. Mary's Cemetery		22. TIME OF INTERMENT 11:00 AM		23. NAME OF INTERMENT SOCIETY St. Mary's Society		24. NAME OF FUNERAL HOME John Doe		25. NAME OF CEMETERY St. Mary's Cemetery	
26. NAME OF FUNERAL HOME John Doe		27. NAME OF CEMETERY St. Mary's Cemetery		28. NAME OF INTERMENT SOCIETY St. Mary's Society		29. NAME OF FUNERAL HOME John Doe		30. NAME OF CEMETERY St. Mary's Cemetery	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 10

1. NAME OF DECEASED  
JAMES J. JONES

2. SEX  
Male

3. AGE  
35

4. DATE OF BIRTH  
10-15-1900

5. PLACE OF BIRTH  
BOSTON, MASS.

6. OCCUPATION  
Carpenter

7. MARITAL STATUS  
Married

8. RACE  
White

9. RELIGION  
Roman Catholic

10. EDUCATION  
High School

11. CAUSE OF DEATH  
Heart Disease

12. MANNER OF DEATH  
Natural

13. PLACE OF DEATH  
Home

14. TIME OF DEATH  
10:30 AM

15. SIGNATURE OF DECEASED  
James J. Jones

16. SIGNATURE OF PHYSICIAN  
Dr. J. H. Smith

17. SIGNATURE OF CLERGYPERSON  
Rev. J. H. Smith

18. SIGNATURE OF WITNESSES  
John Doe, Jane Doe

19. SIGNATURE OF REGISTRAR  
John Doe

20. SIGNATURE OF DECEASED  
James J. Jones

21. PLACE OF INTERMENT  
St. Mary's Cemetery

22. TIME OF INTERMENT  
11:00 AM

23. NAME OF INTERMENT SOCIETY  
St. Mary's Society

24. NAME OF FUNERAL HOME  
John Doe

25. NAME OF CEMETERY  
St. Mary's Cemetery

26. NAME OF FUNERAL HOME  
John Doe

27. NAME OF CEMETERY  
St. Mary's Cemetery

28. NAME OF INTERMENT SOCIETY  
St. Mary's Society

29. NAME OF FUNERAL HOME  
John Doe

30. NAME OF CEMETERY  
St. Mary's Cemetery

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5676 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD.</u>	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <u>ROCKS (RURAL)</u>		c. LENGTH OF STAY IN 1b <u>3 MONTHS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHARON Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALFRED ANDREW GUNTENSPERGER</u>		4. DATE OF DEATH Month Day Year <u>MAY 6 19 59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 10, 1916</u>
9. AGE [In years last birthday] <u>43</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EDGEWOOD ARSENAL</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>ALFRED J. GUNTENSPERGER.</u>		14. MOTHER'S MAIDEN NAME <u>MARY D. ROTH.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>W.I.W.II</u>	
17. INFORMANT <u>MARY GUNTENSPERGER SAME.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (b) <u>NONE</u> (c) <u>NONE</u> DUE TO <u>NONE</u> cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>5-9-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEM.</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Gailer</u>		24a. REC'D BY REGISTRAR <u>MAY 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles J. Gailer</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 5677 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Anna J. Hopkins</u>				4. DATE OF DEATH <u>May 16 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 25, 1878</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Harford Co Md U.S.A</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Francis J. Hopkins</u>				14. MOTHER'S MAIDEN NAME <u>Annie E. Harper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Miss Isabelle Brown</u>		Address <u>Darlington Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Old Age</u> 794x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 14 1947</u> to <u>May 16 1959</u> , that I last saw the deceased alive on <u>May 12 1959</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dudley Phillips</u>				ADDRESS (Street, city or town, state) <u>Darlington Md</u>			
PHYSICIAN'S NAME (Type) <u>Dudley Phillips</u>				DATE SIGNED <u>5/20/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried May 17, 1959</u>		<u>May 17, 1959</u>		<u>Darlington Cem</u>		<u>Harford Co, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. S. Bailey</u>				24a. REC'D BY REGISTRAR <u>Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>	
				DATE <u>MAY 28 '59</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

05500

PLACE OF DEATH (If at home, give street, city, county, and State)		PLACE OF BIRTH (If at home, give street, city, county, and State)	
DATE OF DEATH (Month, day, and year)		TIME OF DEATH (Hour and minute)	
SEX (Male or Female)		AGE (In years, months, and days)	
OCCUPATION (If deceased, give occupation at time of death)		CAUSE OF DEATH (Give full description of disease or injury)	
MANNER OF DEATH (Natural, Accidental, or Suicidal)		MEDICAL HISTORY (Give full description of disease or injury)	
SIGNATURE OF DECEASED (If deceased, give full name)		SIGNATURE OF WITNESSES (Give full names of witnesses)	
SIGNATURE OF PHYSICIAN (Give full name of physician)		SIGNATURE OF JUDGE (Give full name of judge)	
SIGNATURE OF CLERK (Give full name of clerk)		SIGNATURE OF REGISTRAR (Give full name of registrar)	

1

This certificate is to be filled out by the physician or other qualified person who has attended the deceased, or by the coroner or other qualified person who has examined the body. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy is to be sent to the local health officer of the city or county in which the death occurred.

1 **FOR STATE HEALTH DEPT.**

5660

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>62 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Revolution St</u>			d. STREET ADDRESS <u>111 N. Stokes St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>George Warren Hughes</u> First Middle Last			4. DATE OF DEATH <u>May 28</u> 19 <u>59</u> Month Day Year		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/13/1897</u>	9. AGE (last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garage</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Harford, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>George W. Hughes Sr</u>			14. MOTHER'S MAIDEN NAME <u>Laura Anthony</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Geo. W. Hughes 111 N. Stokes</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Beltin, Md</u>		DATE SIGNED <u>5-29-59</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/31/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Harford Hill</u>	
22d. LOCATION (City, town, or county) (State) <u>Harford, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funerary Co., Harford, Md.</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOT STATE  
HEALTH DEPT

5686

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5686

RECEIVED  
JAN 10 1918  
BALTIMORE

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is partially filled out with handwritten text.

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
OCCUPATION: [illegible]  
CAUSE OF DEATH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]





CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

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## 5661 CERTIFICATE OF DEATH

05663

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>York</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u> 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>R.D. # 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Ira</u> Middle <u>Cleveland</u> Last <u>Masemer</u>		4. DATE OF DEATH Month <u>5</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 30, 1885</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
13. FATHER'S NAME <u>Masemer, Eli</u>		14. MOTHER'S MAIDEN NAME <u>Ramer, Ida</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>176-01-1107</u>	
17. INFORMANT <u>Melvin Masemer</u>		Address <u>York, Pa. 6 Summit R.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Occident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>5/2</u> , 19 <u>59</u> , to <u>5/6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/6</u> , 19 <u>59</u> , and that death occurred at <u>7:20 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips</u>		ADDRESS (Street, city or town, state) <u>Dudley Phillips</u> DATE SIGNED <u>5/7/59</u>	
PHYSICIAN'S NAME (Type) <u>Darlington Md</u>		<u>Darlington Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5/10/59</u>	<u>Mumments Church Cem</u>	<u>East Berlin Adams Co Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward R. Baumeister</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 11 '59</u>	
ADDRESS <u>York Pa</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5222

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5662 CERTIFICATE OF DEATH

Reg. Dist. No. 05664

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>				c. LENGTH OF STAY IN 1b <b>6 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FOREST HILL</b>			
				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Virginia MAE Patrick</b>				4. DATE OF DEATH Month Day Year <b>MAY 19 19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 14, 1897</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>JOHN C. MCGRAW</b>				14. MOTHER'S MAIDEN NAME <b>NORA BOGGS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>220-14-2928</b>			
				17. INFORMANT <b>Lonnie Patrick Forest Hill, Md</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anteroseptal Infarction</b> <b>420.1</b> DUE TO <b>Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>5 yrs.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 12th, 1959</b> , to <b>May 19, 1959</b> , that I last saw the deceased alive on <b>May 19th, 1959</b> , and that death occurred at <b>1:35 M.</b> from the causes and on the date stated above.							
A ADDRESS (Street, city or town, state)						DATE SIGNED <b>5/19/59</b>	
ACTUAL SIGNATURE <b>Edward C. Foon, M.D.</b>				ADDRESS <b>211 N. Union Ave.</b>			
PHYSICIAN'S NAME (Type) <b>Edward C. Foon, M.D.</b>				ADDRESS <b>Haure de Grace, Ind.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>May 22, 1959</b>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Douglas Cem.</b>	
						22d. LOCATION (City, town, or county) (State) <b>Harford Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. D. Bailey</b>				ADDRESS <b>Harlington Md</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 22 59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Charles S. Keenan</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1991



## 5663 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase Md.</u>	
c. LENGTH OF STAY IN TB <u>20 yrs.</u>		d. STREET ADDRESS <u>900 S. Market</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jessie Jackson Poist</u>		4. DATE OF DEATH Month Day Year <u>5/12/59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/16/1884</u>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTH PLACE (State or foreign country) <u>Port Deposit, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wesley Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Klora Woodrow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Chas. S. Poist</u>		Address <u>900 S. Market St., Harford Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) <u>YEARS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/14</u> , 19 <u>57</u> , to <u>5/12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/11</u> , 19 <u>59</u> , and that death occurred at <u>11:05 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Irwin Randall Ross</u> M.D.		200 N. UNION AVE	
PHYSICIAN'S NAME (Type) <u>IRWIN RANDALL ROSS</u>		<u>HARFORD DE GRACE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Euri</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Chase Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Connington Ken, Harford Chase, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>MAY 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05005

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 32

# DEATH CERTIFICATE OF DEATH

DEATH CERTIFICATE OF DEATH  
 (To be filled out by the physician or other qualified person who attended the deceased during the last illness.)

1

<p>1. Name of deceased: <u>John Doe</u></p>	
<p>2. Date of death: <u>10/15/1964</u></p>	
<p>3. Place of death: <u>Home</u></p>	
<p>4. Age: <u>65</u> years</p>	
<p>5. Sex: <u>Male</u></p>	
<p>6. Race: <u>White</u></p>	
<p>7. Marital status: <u>Married</u></p>	
<p>8. Occupation: <u>Teacher</u></p>	
<p>9. Cause of death: <u>Myocardial infarction</u></p>	
<p>10. Immediate cause: <u>Coronary artery disease</u></p>	
<p>11. Underlying cause: <u>Arteriosclerosis</u></p>	
<p>12. Contributing cause: <u>None</u></p>	
<p>13. Manner of death: <u>Natural</u></p>	
<p>14. Signature of physician: <u>[Signature]</u></p>	
<p>15. Date of certification: <u>10/15/1964</u></p>	

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

5679

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

05666

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Joppa</u>		LENGTH OF STAY (in this place) <u>10 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Joppa</u>		STREET ADDRESS (If rural give location) <u>/</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Henry Basye Read</u>				<b>4. DATE OF DEATH</b> (Month) <u>May</u> (Day) <u>21</u> (Year) <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug. 31, 1886</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Read</u>				14. MOTHER'S MAIDEN NAME <u>Emma Payne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>228-18-4867</u>		17. INFORMANT & ADDRESS <u>Thomas H. Read, Rosedale, Maryland.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>151X Gastric hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>Carcinoma of the stomach</u>						<u>8 months 7</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>March 23</u> , 19 <u>59</u> , to <u>May 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>59</u> , and that death occurred at <u>1:12 PM</u> , from the causes and on the date stated above. <b>SIGNATURE</b> <u>Willard P. Hudson</u> <b>ADDRESS</b> (Street, city, town, state) <u>Forest Hill, Maryland</u> <b>DATE SIGNED</b> <u>May 22, 1959</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 24, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		LOCATION (City, town, or county) (State) <u>Bel Air, Harford, Maryland.</u>	
24. REC'D BY REGISTRAR <u>Arthur S. Kious</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCombs</u>		ADDRESS <u>Abingdon, Md</u>	
DATE <u>MAY 26 '59</u>							

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

05308

5078

Age, Date, Sex

DATE OF DEATH

PLACE OF DEATH

Hartford

Maryland

MARYLAND

Hartford

John

10 yrs.

John

Mar. 31, 1886

Married

White

Stationary Fireman

U.S. Govt.

Virginia

John Payne

Thomas Read

Thomas H. Read, Rosedale, Maryland.

228-18-4867

NO

Extra hospital

Witness of the death

Signature X

May 24, 1920 Bel Air Memorial Gardens Bel Air, Hartford, Maryland.

Burial

MAY 24 1920

RECEIVED

RECEIVED  
MAY 24 1920  
BALTIMORE  
STATE DEPARTMENT OF HEALTH  
BALTIMORE

## 5664 CERTIFICATE OF DEATH

05667

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>				c. LENGTH OF STAY IN <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Letcher Alexander Richardson</u>				4. DATE OF DEATH Month Day Year <u>May 17 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 28 - 1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>John Richardson</u>				14. MOTHER'S MAIDEN NAME <u>Peggy Moxley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT <u>Thomas C Richardson Bel Air Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>Chronic Cardio-vascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 12</u> , 19 <u>59</u> , to <u>May 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 17</u> , 19 <u>59</u> , and that death occurred at <u>10:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city or town, state) <u>Forest Hill, Maryland</u> DATE SIGNED <u>May 18, 1959</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>May 19 - 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster</u> ADDRESS <u>Bel Air Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Form 100-1 (Rev. 1-1-60) Maryland State Department of Health - Baltimore, Md. 21201

1

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

88803

NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH 4/4/68	
PLACE OF DEATH FEDERAL BUREAU OF INVESTIGATION WASHINGTON, D.C.		DATE OF DEATH 4/4/68	
MANNER OF DEATH Suicide		DATE OF DEATH 4/4/68	
CAUSE OF DEATH Self-inflicted gunshot wound		DATE OF DEATH 4/4/68	
DISEASE OR INJURY Suicide		DATE OF DEATH 4/4/68	
LOCALITY OF DEATH Washington, D.C.		DATE OF DEATH 4/4/68	
AGE 35		DATE OF DEATH 4/4/68	
SEX Male		DATE OF DEATH 4/4/68	
RACE White		DATE OF DEATH 4/4/68	
EDUCATION High School Graduate		DATE OF DEATH 4/4/68	
OCCUPATION Attorney		DATE OF DEATH 4/4/68	
RELIGION Methodist		DATE OF DEATH 4/4/68	
MARRIAGE Married		DATE OF DEATH 4/4/68	
SPOUSE Jane Patricia Ray		DATE OF DEATH 4/4/68	
CHILDREN None		DATE OF DEATH 4/4/68	
BIRTH May 19, 1932		DATE OF DEATH 4/4/68	
PLACE OF BIRTH Alton, Illinois		DATE OF DEATH 4/4/68	
FATHER Ralph S. Ray		DATE OF DEATH 4/4/68	
MOTHER Lillian M. Ray		DATE OF DEATH 4/4/68	
SISTER None		DATE OF DEATH 4/4/68	
BROTHER None		DATE OF DEATH 4/4/68	
GRANDFATHER None		DATE OF DEATH 4/4/68	
GRANDMOTHER None		DATE OF DEATH 4/4/68	
AUNT None		DATE OF DEATH 4/4/68	
UNCLE None		DATE OF DEATH 4/4/68	
Nephew None		DATE OF DEATH 4/4/68	
Niece None		DATE OF DEATH 4/4/68	
Cousin None		DATE OF DEATH 4/4/68	
Sister-in-law None		DATE OF DEATH 4/4/68	
Brother-in-law None		DATE OF DEATH 4/4/68	
Parent-in-law None		DATE OF DEATH 4/4/68	
Grandparent None		DATE OF DEATH 4/4/68	
Other relatives None		DATE OF DEATH 4/4/68	
Other persons None		DATE OF DEATH 4/4/68	
Other None		DATE OF DEATH 4/4/68	

## 5665 CERTIFICATE OF DEATH

05668

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HARVARD GRACE</b>		c. LENGTH OF STAY IN 1b <b>45 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESAPEAKE DRIVE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>HARVARD GRACE 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HOWARD GRANT SHAFER</b>				4. DATE OF DEATH Month Day Year <b>MAY 5 1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR. 8, 1898</b>	9. AGE (In years, lost birthday) yrs. Months Days Hours Min. <b>61</b>		IF UNDER 1 YEAR: IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUSINESS MAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME APPLIANCE</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CHARLES T. SHAFER</b>				14. MOTHER'S MAIDEN NAME <b>CORA WHITMER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>178-10-944</b>		17. INFORMANT Address <b>Mrs. EARLY M. Shafer - Harvard Grace Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Old rheumatic heart disease</b> DUE TO <b>and Arteriosclerotic Cardio-</b> (c) <b>Vascular Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>4 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>Feb. 8th 1954</b> , to <b>May 5th 1959</b> , that I last saw the deceased alive on <b>May 5th 1959</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Harvard Grace, Md.</b> DATE SIGNED <b>5/5/59</b> <b>at 11:30 AM</b>							
ACTUAL SIGNATURE <b>Edward C. Loo, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Edward C. Loo, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5-8-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BELAIR MEMORIAL GARDEN - HARFORD Co.</b>		22d. LOCATION (City, town, or county) (State) <b>MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. M. Mitchell</b>			ADDRESS <b>Harvard Grace, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 8 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

## CERTIFICATE OF DEATH

I, <u>JOHN J. SMITH</u> , Registrar, do hereby certify that on <u>12-15-1918</u> at <u>BALTIMORE</u> , Maryland, died <u>JOHN J. SMITH</u> , aged <u>65</u> years, male, white, born <u>12-15-1853</u> at <u>BALTIMORE</u> , Maryland, of <u>JOHN J. SMITH</u> and <u>MARY J. SMITH</u> .		I, <u>JOHN J. SMITH</u> , Registrar, do hereby certify that on <u>12-15-1918</u> at <u>BALTIMORE</u> , Maryland, died <u>JOHN J. SMITH</u> , aged <u>65</u> years, male, white, born <u>12-15-1853</u> at <u>BALTIMORE</u> , Maryland, of <u>JOHN J. SMITH</u> and <u>MARY J. SMITH</u> .	
Name of Deceased: <u>JOHN J. SMITH</u>		Date of Death: <u>12-15-1918</u>	
Place of Death: <u>BALTIMORE</u>		Cause of Death: <u>HEART DISEASE</u>	
Occupation: <u>CLERK</u>		Manner of Death: <u>NATURAL</u>	
Burial Place: <u>BALTIMORE</u>		Interment: <u>YES</u>	
Signature of Registrar: <u>JOHN J. SMITH</u>		Signature of Physician: <u>JOHN J. SMITH</u>	
Date of Registration: <u>12-15-1918</u>		Date of Interment: <u>12-15-1918</u>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD. IT IS NOT VALID FOR ANY OTHER PURPOSES.

## 5680 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. LENGTH OF STAY IN 1b <u>6 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u> <u>Aberdeen Proving Ground, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SUZAN</u> Middle <u>DANIESE</u> Last <u>SHAFFER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 15, 1958</u>
9. AGE (In years lost birthday) yrs. <u>6</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>10</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Joseph Shaffer</u>		14. MOTHER'S MAIDEN NAME <u>Georgenia Erickson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>7 Grant Street</u> <u>Aberdeen, Md.</u>	
17. INFORMANT <u>Mother</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Increased intracranial pressure.</u> <u>752X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital hydrocephalus.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 9, 1959, to May 10, 1959, that I last saw the deceased alive on May 10, 1959, and that death occurred at 6 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE J. B. Bryant, Jr. M.D. 7/11/59  
PHYSICIAN'S NAME (Type) J. B. BRYANT, JR., MAJOR, MC USAH, APG, Md. Busti, Phantagosa Co.

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>7/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Busti Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>New York</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Sarring Aberdeen Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 18 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Knaus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DEATH CERTIFICATE OF DEATH

FILE NO. 118

DEATH OF DEATH

DEATH OF DEATH

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*J. J. J. J. J.*



# 5681 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05670

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> c. LENGTH OF STAY IN lb <u>31</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>P.O. Box #171</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> d. STREET ADDRESS <u>P.O. Box #171</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Kristie Lynn Shivers</u> First Middle Last 4. DATE OF DEATH <u>May 27</u> Month Day Year <u>19 59</u>		5. SEX <u>F</u> 6. COLOR OR RACE <u>E</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Jan 10, 1959</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) <u>—</u> yrs. <u>4</u> Months <u>17</u> Days <u>—</u> Hours <u>—</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u> 11. BIRTHPLACE (State or foreign country) <u>Kansas</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Frank Allen Shivers</u> 14. MOTHER'S MAIDEN NAME <u>Elsie Ann Murray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Father: P.O. Box 171 Aberdeen, Md.</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Gerald C Palmer</u> EXAMINER'S NAME (Type) <u>Gerald C Palmer, M.D.</u> 22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>5/29/1959</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Aberdeen Maryland</u>		DATE SIGNED <u>5-27-59</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Be/Air-Md</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Sarring Aberdeen, Md.</u> ADDRESS 24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUN 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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## 05729

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05671

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NS Route 1</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Donald Franklin Smith</u>		4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 18 1933</u>
9. AGE (in years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u>25</u> Days <u>25</u>	IF UNDER 24 HRS Hours <u>25</u> Min. <u>25</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Test Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aberdeen P.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Scarbrough Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Vernon F Smith</u>		14. MOTHER'S MAIDEN NAME <u>Beulah Cullum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Navy</u>		16. SOCIAL SECURITY NO. <u>312-32-624</u>	
17. INFORMANT <u>Anna Lee Smith</u>		Address <u>Street Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Cervical Vertebra</u> <u>815X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture L. femur</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) <u>Auto accident with motorcycle type</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>5:23</u> p.m. <u>1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NS Route 1</u>	20f. (City or town) <u>Baldwin</u> (County) <u>Harford</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <u>Bertin</u> DATE SIGNED <u>5-23-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>5/26/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Southern</u>	22d. LOCATION (City, town, or county) <u>Doubling Harford Md.</u> (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Rust</u>		24a. REC'D BY REGISTRAR <u>Garrettville Md.</u> DATE <u>MAY 26 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Garrettville Md.</u>	

MEDICAL CERTIFICATION

12

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE DEPARTMENT OF HEALTH - BATHING  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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STATE DEPARTMENT OF HEALTH  
BATHING

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

05672

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND CITY OR TOWN <u>Bel Air</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>206 Penna. Ave.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Harford</u> CITY OR TOWN <u>Bel Air</u> STREET ADDRESS <u>206 Penna. Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>CHARLES Ryland STEVENS Jr.</u>				4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>8</u> (Year) <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept. 6, 1932</u>	9. AGE last birthday <u>26</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>I.B.M. operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glen L. Martin</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles R. Stevens, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Laura Maria Bailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-30-6217</u>		17. INFORMANT & ADDRESS <u>Maria Harla Stevens, wife, above</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
592X IMMEDIATE CAUSE (A) <u>Suppuration from Aspirated Ventricle</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Glomerular Nephritis</u>						<u>10 YEARS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/10, 1958</u> , to <u>5/8, 1959</u> , that I last saw the deceased alive on <u>4/16, 1959</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert Barthel</u>				ADDRESS (Street, city, town, state) <u>FOREST HILL MARYLAND</u> DATE SIGNED <u>5/6/59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/12/59</u>		NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>		REGISTRAR'S SIGNATURE <u>Charles E. Schimunek</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schimunek</u> ADDRESS <u>Funeral Home 3331 Brehms Lane</u>			



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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

# CERTIFICATE OF DEATH

5000

REG. NO. 100

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESS

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF CLERK

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF CONSTABLE

19. SIGNATURE OF ALDERMAN

20. SIGNATURE OF TOWNSHIP CLERK

21. SIGNATURE OF COUNTY CLERK

22. SIGNATURE OF STATE CLERK

23. SIGNATURE OF SECRETARY OF HEALTH

24. SIGNATURE OF ASSISTANT SECRETARY

25. SIGNATURE OF CHIEF OF BUREAU

26. SIGNATURE OF DEPUTY CHIEF

27. SIGNATURE OF ASSISTANT CHIEF

28. SIGNATURE OF CLERK OF BOARD

29. SIGNATURE OF MEMBER OF BOARD

30. SIGNATURE OF CHAIRMAN OF BOARD

31. SIGNATURE OF VICE CHAIRMAN

32. SIGNATURE OF SECRETARY OF BOARD

33. SIGNATURE OF ASSISTANT SECRETARY OF BOARD

34. SIGNATURE OF CLERK OF BOARD

35. SIGNATURE OF MEMBER OF BOARD

36. SIGNATURE OF CHAIRMAN OF BOARD

37. SIGNATURE OF VICE CHAIRMAN

38. SIGNATURE OF SECRETARY OF BOARD

39. SIGNATURE OF ASSISTANT SECRETARY OF BOARD

40. SIGNATURE OF CLERK OF BOARD

41. SIGNATURE OF MEMBER OF BOARD

42. SIGNATURE OF CHAIRMAN OF BOARD

43. SIGNATURE OF VICE CHAIRMAN

44. SIGNATURE OF SECRETARY OF BOARD

45. SIGNATURE OF ASSISTANT SECRETARY OF BOARD

46. SIGNATURE OF CLERK OF BOARD

47. SIGNATURE OF MEMBER OF BOARD

48. SIGNATURE OF CHAIRMAN OF BOARD

49. SIGNATURE OF VICE CHAIRMAN

50. SIGNATURE OF SECRETARY OF BOARD

51. SIGNATURE OF ASSISTANT SECRETARY OF BOARD

52. SIGNATURE OF CLERK OF BOARD

53. SIGNATURE OF MEMBER OF BOARD

54. SIGNATURE OF CHAIRMAN OF BOARD

55. SIGNATURE OF VICE CHAIRMAN

56. SIGNATURE OF SECRETARY OF BOARD

57. SIGNATURE OF ASSISTANT SECRETARY OF BOARD

58. SIGNATURE OF CLERK OF BOARD

59. SIGNATURE OF MEMBER OF BOARD

60. SIGNATURE OF CHAIRMAN OF BOARD

61. SIGNATURE OF VICE CHAIRMAN

62. SIGNATURE OF SECRETARY OF BOARD

63. SIGNATURE OF ASSISTANT SECRETARY OF BOARD

64. SIGNATURE OF CLERK OF BOARD

65. SIGNATURE OF MEMBER OF BOARD

66. SIGNATURE OF CHAIRMAN OF BOARD

67. SIGNATURE OF VICE CHAIRMAN

68. SIGNATURE OF SECRETARY OF BOARD

69. SIGNATURE OF ASSISTANT SECRETARY OF BOARD

70. SIGNATURE OF CLERK OF BOARD

71. SIGNATURE OF MEMBER OF BOARD

72. SIGNATURE OF CHAIRMAN OF BOARD

73. SIGNATURE OF VICE CHAIRMAN

74. SIGNATURE OF SECRETARY OF BOARD

75. SIGNATURE OF ASSISTANT SECRETARY OF BOARD

76. SIGNATURE OF CLERK OF BOARD

77. SIGNATURE OF MEMBER OF BOARD

78. SIGNATURE OF CHAIRMAN OF BOARD

79. SIGNATURE OF VICE CHAIRMAN

80. SIGNATURE OF SECRETARY OF BOARD

81. SIGNATURE OF ASSISTANT SECRETARY OF BOARD

82. SIGNATURE OF CLERK OF BOARD

83. SIGNATURE OF MEMBER OF BOARD

84. SIGNATURE OF CHAIRMAN OF BOARD

85. SIGNATURE OF VICE CHAIRMAN

86. SIGNATURE OF SECRETARY OF BOARD

87. SIGNATURE OF ASSISTANT SECRETARY OF BOARD

88. SIGNATURE OF CLERK OF BOARD

89. SIGNATURE OF MEMBER OF BOARD

90. SIGNATURE OF CHAIRMAN OF BOARD

91. SIGNATURE OF VICE CHAIRMAN

92. SIGNATURE OF SECRETARY OF BOARD

93. SIGNATURE OF ASSISTANT SECRETARY OF BOARD

94. SIGNATURE OF CLERK OF BOARD

95. SIGNATURE OF MEMBER OF BOARD

96. SIGNATURE OF CHAIRMAN OF BOARD

97. SIGNATURE OF VICE CHAIRMAN

98. SIGNATURE OF SECRETARY OF BOARD

99. SIGNATURE OF ASSISTANT SECRETARY OF BOARD

100. SIGNATURE OF CLERK OF BOARD

101. SIGNATURE OF MEMBER OF BOARD

102. SIGNATURE OF CHAIRMAN OF BOARD

103. SIGNATURE OF VICE CHAIRMAN

104. SIGNATURE OF SECRETARY OF BOARD

105. SIGNATURE OF ASSISTANT SECRETARY OF BOARD

106. SIGNATURE OF CLERK OF BOARD

107. SIGNATURE OF MEMBER OF BOARD

108. SIGNATURE OF CHAIRMAN OF BOARD

109. SIGNATURE OF VICE CHAIRMAN

110. SIGNATURE OF SECRETARY OF BOARD

111. SIGNATURE OF ASSISTANT SECRETARY OF BOARD

112. SIGNATURE OF CLERK OF BOARD

113. SIGNATURE OF MEMBER OF BOARD

114. SIGNATURE OF CHAIRMAN OF BOARD

115. SIGNATURE OF VICE CHAIRMAN

116. SIGNATURE OF SECRETARY OF BOARD

117. SIGNATURE OF ASSISTANT SECRETARY OF BOARD

118. SIGNATURE OF CLERK OF BOARD

119. SIGNATURE OF MEMBER OF BOARD

120. SIGNATURE OF CHAIRMAN OF BOARD

121. SIGNATURE OF VICE CHAIRMAN

122. SIGNATURE OF SECRETARY OF BOARD

123. SIGNATURE OF ASSISTANT SECRETARY OF BOARD

124. SIGNATURE OF CLERK OF BOARD

125. SIGNATURE OF MEMBER OF BOARD

126. SIGNATURE OF CHAIRMAN OF BOARD

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05673

Item 20 Film 242 5-14-59 ans

5667

Item 9, Film G-242, 5-7-59 md

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanalee Grace 1 1/2 hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Israel</u> Middle <u>Taylor</u> Last		4. DATE OF DEATH Month <u>MAY</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 16-1879</u>
9. AGE (In years last birthday) <u>80</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>19</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STREET, Md</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RICHARD TAYLOR</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA SCARFF</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MILDRED T. BAILEY</u>	
17. INFORMANT <u>Forest Hill, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>812X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto-pedestrian type</u>	
20c. TIME OF INJURY Month, Day, Year <u>5-2-59</u> Hour <u>2</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Harford</u> (County) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>Bella, Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 5, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HIGHLAND CEM.</u>		22d. LOCATION (City, town, or county) <u>STREET</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkin</u>		24a. REC'D BY REGISTRAR <u>Delta, Pa.</u>	
		24b. REGISTRAR'S SIGNATURE <u>DATE MAY 5 '59</u>	

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BP

1988

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1988

1. NAME OF DECEASED: John Doe

2. SEX: Male

3. AGE: 45

4. DATE OF BIRTH: 10/15/1943

5. PLACE OF BIRTH: Washington, D.C.

6. OCCUPATION: Teacher

7. MARITAL STATUS: Married

8. SOCIAL SECURITY NUMBER: 123-45-6789

9. ADDRESS: 123 Main St, Baltimore, MD 21201

10. PHONE NUMBER: 555-1234

11. DATE OF DEATH: 11/10/1988

12. TIME OF DEATH: 10:00 AM

13. PLACE OF DEATH: Home

14. CAUSE OF DEATH: Myocardial Infarction

15. MANNER OF DEATH: Natural

16. SIGNATURE OF EXAMINER: [Signature]

17. SIGNATURE OF ATTENDING PHYSICIAN: [Signature]

18. SIGNATURE OF CORONER: [Signature]

19. SIGNATURE OF WITNESS: [Signature]

20. SIGNATURE OF JURY: [Signature]

21. SIGNATURE OF DISTRICT ATTORNEY: [Signature]

22. SIGNATURE OF CLERK: [Signature]

23. SIGNATURE OF JUDGE: [Signature]

24. SIGNATURE OF SHERIFF: [Signature]

25. SIGNATURE OF DEPUTY SHERIFF: [Signature]

26. SIGNATURE OF JAILER: [Signature]

27. SIGNATURE OF WARDEN: [Signature]

28. SIGNATURE OF CHIEF OF POLICE: [Signature]

29. SIGNATURE OF DETECTIVE: [Signature]

30. SIGNATURE OF OFFICER: [Signature]

31. SIGNATURE OF SGT.: [Signature]

32. SIGNATURE OF CAPT.: [Signature]

33. SIGNATURE OF MAJOR: [Signature]

34. SIGNATURE OF LIEUTENANT: [Signature]

35. SIGNATURE OF SERGEANT: [Signature]

36. SIGNATURE OF PRIVATE: [Signature]

37. SIGNATURE OF CORP.: [Signature]

38. SIGNATURE OF PVT.: [Signature]

39. SIGNATURE OF PFC.: [Signature]

40. SIGNATURE OF PMA.: [Signature]

41. SIGNATURE OF PMO.: [Signature]

42. SIGNATURE OF PMO.: [Signature]

43. SIGNATURE OF PMO.: [Signature]

44. SIGNATURE OF PMO.: [Signature]

45. SIGNATURE OF PMO.: [Signature]

46. SIGNATURE OF PMO.: [Signature]

47. SIGNATURE OF PMO.: [Signature]

48. SIGNATURE OF PMO.: [Signature]

49. SIGNATURE OF PMO.: [Signature]

50. SIGNATURE OF PMO.: [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05674

5668

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kalmaria</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Howard A Thompson</u>		4. DATE OF DEATH <u>May 15 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23 1917</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>15</u> IF UNDER 24 HRS: Hours <u>10</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Deputy Sheriff</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co Md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elwood Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Pearl Kelly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If not, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-09-9654</u>	
17. INFORMANT <u>Mrs Howard Thompson</u> Address <u>Bel Air, Md R. 10</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) <u>420.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>May 18 1959</u>		22b. DATE THEREOF <u>May 18 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Barlington Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Barlington, Md</u>		24a. REC'D BY REGISTRAR <u>MAY 28 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Carlton J. Smith</u>	

45534

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5008

1  
STATE  
HEALTH DEPT



1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Usual residence: [illegible]  
7. Date of death: [illegible]  
8. Place of death: [illegible]  
9. Cause of death: [illegible]  
10. Manner of death: [illegible]  
11. Signature of medical examiner: [illegible]  
12. Date of certification: [illegible]

Form with multiple sections for medical history, physical examination, and certification. Includes checkboxes for various conditions and a large area for the medical examiner's signature and notes.



## 5683 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>31 Aberdeen</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital Aberdeen Proving Ground, Maryland</b>		d. STREET ADDRESS <b>Site B-4 Post Trailer Park</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>KAREN</b> Middle <b>MARIE</b> Last <b>THYNG</b>		4. DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 May 1959</b>
9. AGE (In years last birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Raymond Boyd Th yng</b>		14. MOTHER'S MAIDEN NAME <b>Vera Marie Disler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Father</b>		Address <b>Site B-4 Post Trailer Park Aberdeen, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO 776x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 3</b> , 19 <b>59</b> , to <b>May 4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 3</b> , 19 <b>59</b> , and that death occurred at <b>2:35 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>4 May 59</b>			
ACTUAL SIGNATURE <b>John Z Delp</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>JOHN Z DELP CAPT MC</b>		<b>USAH, APG, Md.</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF <b>5/7/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Post Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Aberdeen Proving Gr. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Darrington Aberdeen Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>MAY 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

## 5883 CERTIFICATE OF DEATH

NAME OF DECEASED (Print Name) _____ (Last, first, middle) _____ (Sex) _____ (Age) _____ (Date of Birth) _____ (Place of Birth) _____ (Married) _____ (Single) _____ (Widow) _____ (Divorced) _____ (Other) _____		PLACE OF DEATH (Print Name) _____ (Address) _____ (City) _____ (State) _____ (Zip) _____ (County) _____ (Precinct) _____ (Ward) _____ (Block) _____ (Lot) _____ (Other) _____	
DATE OF DEATH (Print Date) _____ (Month) _____ (Day) _____ (Year) _____ (Time) _____ (Hour) _____ (Minute) _____ (Second) _____ (Other) _____		CAUSE OF DEATH (Print Name) _____ (Address) _____ (City) _____ (State) _____ (Zip) _____ (County) _____ (Precinct) _____ (Ward) _____ (Block) _____ (Lot) _____ (Other) _____	

SIGNATURE OF DECEASED (Print Name) _____ (Address) _____ (City) _____ (State) _____ (Zip) _____ (County) _____ (Precinct) _____ (Ward) _____ (Block) _____ (Lot) _____ (Other) _____		SIGNATURE OF DECEASED (Print Name) _____ (Address) _____ (City) _____ (State) _____ (Zip) _____ (County) _____ (Precinct) _____ (Ward) _____ (Block) _____ (Lot) _____ (Other) _____	
SIGNATURE OF DECEASED (Print Name) _____ (Address) _____ (City) _____ (State) _____ (Zip) _____ (County) _____ (Precinct) _____ (Ward) _____ (Block) _____ (Lot) _____ (Other) _____		SIGNATURE OF DECEASED (Print Name) _____ (Address) _____ (City) _____ (State) _____ (Zip) _____ (County) _____ (Precinct) _____ (Ward) _____ (Block) _____ (Lot) _____ (Other) _____	

5684

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL-BEL AIR</u>		LENGTH OF STAY (in this place) <u>45 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL-BEL AIR</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Churchville Road</u>		1		STREET ADDRESS (If rural give location) <u>Churchville Road</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Betty Young Umbarger</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>MAY 28 1959</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>August 27, 1875</u>		<b>9. AGE last birthday</b> <u>83</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farming</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWNER</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>John Young</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Francis Kirby</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>219-36-1284</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Joseph Y. Umbarger, Bel Air, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>422.1 IMMEDIATE CAUSE</b> (A) <u>Cerebro-vascular accident (thrombosis)</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>24 hours</u>	
<b>ANTECEDENT CAUSE(S)</b> DUE TO (B) <u>Arteriosclerotic Cardiovascular disease</u>						<u>1 year</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>URINARY infection; cardiac failure, compensator</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Jan 18</u>, 19<u>59</u>, to <u>MAY 28</u>, 19<u>59</u>, that I last saw the deceased alive on <u>MAY 28</u>, 19<u>59</u>, and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Paul S. Stenetz Jr.</u>				<b>ADDRESS (Street, city, town, state)</b> <u>M.D. 115 Fulford Ave, Bel Air</u>		<b>DATE SIGNED</b> <u>5/28/59</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>May 31, 1959</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Zion Methodist Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Fountain Green, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kneass</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph W. Foster</u>			
<b>DATE</b> <u>JUN 2 '59</u>				<b>ADDRESS</b> <u>W. Broadway + Williams St, BEL AIR, Maryland</u>			

## INSTRUCTIONS

**1** hours after death.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



5669 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
c. LENGTH OF STAY IN IB <u>D.O.A.</u>		d. STREET ADDRESS <u>1 14 Rigdon Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>VACIK</u> Last <u>VACIK</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-29-04</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fire-man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.P.G.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Vacik</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mikolalik</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Novak Funeral Home - 3513 Brighton Rd</u>	
17. INFORMANT Address <u>Pittsburgh Pa.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>30 MIN</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 27, 1959</u> , to <u>MAY 27, 1959</u> , that I last saw the deceased alive on <u>MAY 27, 1959</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip W. Human</u> M.D.		ADDRESS (Street, city or town, state) <u>307 Hickory</u> DATE SIGNED <u>MAY 27, 59</u>	
PHYSICIAN'S NAME (Type) <u>Philip W. Human</u>		<u>BEL AIR, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>5/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Highwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pittsburgh, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Garrison</u> ADDRESS <u>Aberdeen, Maryland</u>		24. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. The first step is to identify the problem or question that needs to be addressed. This involves understanding the context and the specific requirements of the task.

## 5670 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 ABERDEEN</u>			
c. LENGTH OF STAY IN 1b <u>9 DAYS</u>				d. STREET ADDRESS <u>1305 D Augusta</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>B</u> Last <u>VEHORINO</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 3-1878</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Baker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Anthony VEHORINO</u>				14. MOTHER'S MAIDEN NAME <u>MARIA Capitelli</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>John R. Vettorino</u> Address <u>305 D. Augusta St. Harford, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO <u>757.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Surgery for Polycystic Disease of Kidney</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 15</u> , 19 <u>57</u> , to <u>May 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 21</u> , 19 <u>59</u> , and that death occurred at <u>5:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Don J. Bryant</u>				M.D. <u>610 S Union Ave</u>			
PHYSICIAN'S NAME (Type) <u>1</u>				DATE SIGNED <u>Home de Grace Md</u>			
22. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		22d. LOCATION (City, town, or county) (State) <u>Woodham R.D. N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>VIGLIANTE FUNERAL HOME</u> ADDRESS <u>406 ROGERS AVE</u>				24a. REC'D BY REGISTRAR <u>DATE MAY 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

